



Community empowerment for improving health services¹

Kerina Tull

University of Leeds Nuffield Centre for International Health and Development

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Question

- *What processes for increasing community empowerment for improving the accountability and quality of health services have been used in the DRC or other country contexts?*
- *Is there any evidence of use of community grant making for communities to prioritise and deliver some areas of change themselves? This may include programmes promoting understanding of rights and changing expectations of services.*

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¹ One of a series of health-related reports on the Democratic Republic of Congo.

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1. Summary

Moving beyond simple participation, there has also been a surge of support for community evaluations, where community members play a direct role in evaluating the performance of health care workers and the health system (Wisniewski and Yongho, 2014 unpublished). Processes and programmes are in place to increase community empowerment in terms of health care in the Democratic Republic of Congo (DRC), with varying degrees of success. Key points are listed below:

- *Expectations on health services:* Research from DRC on use of maternal health services in Muanda and Bolenge health zones found that women were unaware of their entitlements and rights (Mafuta et al., 2018). They believed that they were laypersons and therefore unable to judge health providers.
Secondary analysis found that factors influencing the capacity of women to voice their concerns in DRC rural settings are mainly associated with insufficient knowledge and socio-cultural context (Mafuta et al., 2018). These findings suggest that initiatives to implement social accountability have to address community capacity-building, health providers' responsiveness, and socio-cultural norms issues.
- *Improving accountability:* The following factors are identified as facilitators of social accountability initiatives: community associations and groups; experiences in social mobilisation and networking; cultural diversity and marginalised population; women's status and participation in community groups' activities; existing media and access to information; supportive regulatory environment; resources, and negotiation ability (Mafuta et al., 2016).
- *Programmes promoting understanding of rights:* A review of the literature from low- and/or middle-income countries describing at least one measure to enhance community accountability revealed that many providers complained that patient charters gave patients' rights without emphasising their responsibilities. This led to patients 'expecting miracles' and to health workers being 'taken for granted;' and that the charter failed to recognise health workers' own stresses and challenges (Molyneux et al., 2012).
- Community scorecards have been conceived to increase accountability and responsiveness of service providers (Ho et al., 2015). In eastern DRC, implementation of scorecards as part of the *Tuungane* ("Let's Unite" in Kiswahili) programme resulted in increased transparency and community participation in health facility management, as well as improved quality of care. Although there was an improvement in empowerment in lower levels, appeals to higher levels were less successful (Wisniewski et al., 2018).
- *Improving quality of health services:* In the DRC, the community of Yakoma created a health co-operative that they named *Tosalisana*, which means "let's help ourselves" in Lingala (IMA, 2018). This resulted in an increase in maternity service use at the main hospital – which has also taken charge of its operating expenses. Qualitative analysis found that participants saw improvements in health services, and that those impacts were concentrated at the levels at which the community or health workers had direct control. This phenomenon was also observed in the *Tuungane* evaluation in eastern DRC (Wisniewski and Lusamba-Dikassa, 2018 unpublished).
- *Evidence on community grants:* A component of the *Tuungane* intervention was the distribution of development grants to community committees. Committees invested the grants in projects related to agriculture, education, health, water and sanitation, and

transport. However, the project's effect on community cohesion, levels of trust, and transparency were disappointing. Further, there was some evidence that economic status decreased in intervention areas (Wisniewski and Yongho, 2014 unpublished).

- The experts consulted for the review confirmed that currently there are no grants for DRC communities to prioritise and deliver some areas of change themselves.

Participatory budgeting is a system in which citizens have control over how public funds are allocated. Although a formal evaluation is not yet available, this approach has shown promise in the DRC, where a participatory budgeting intervention in South Kivu Province contributed in an increase in public investment from 0% to 11.6% over the course of one year (Wisniewski and Yongho, 2014: 10, unpublished).

- In Kenya, the innovative Health Sector Services Fund (HSSF) had a positive impact on community facilities. Residents are responsible for planning, budgeting and implementation of HSSF activities (KEMRI Wellcome Trust, 2014b; Goodman et al., 2018).
- *Programmes changing expectations of services:* Data has shown that communities have been inspired to take entrepreneurial initiatives and action by animatorship (McElwee et al., 2018). In a pilot project by Oxfam in Wendji, *Réunion Mixte* (joint meeting) provided an important space for community members to instigate focused discussions on important issues, e.g. to prevent confusion over the appropriate amount to pay for access to maternal services (Lindley-Jones, 2017).
- Evidence has shown that other countries have empowered communities and improved their health services: Niger has successfully included community dialogues and media messages (cinema, community radio, and theatre) to disseminate information on promotion and prevention (Sharkey et al., 2014). Ethiopia has developed innovative mechanisms to support the community; the Ministry of Health prioritised the implementation of community-based preventive, promotive, and curative care through the health extension programme (Balcha et al., 2015).

Due to the lack of available evidence from the DRC, lessons learned from other transformative country programmes (i.e. to generate empowerment) are also incorporated into this report. Peer-reviewed and “grey” literature was included. Additionally, the input of professionals who have been involved in implementing community participation interventions has been sought and is included as appropriate. Although power relations are critical to both gender and accountability, the evidence found was ‘gender-blind.’ However, most of the service evaluations available are linked to maternal and child health. Disability was not a focus of this rapid review.

2. Expectations of health services

Perceptions of quality of care

Recent research examined the relationship between patients' perceptions of quality, and the objective level of quality at government health facilities in the Democratic Republic of Congo (Wisniewski et al., 2018). Overall, it found that patients are not particularly accurate in their assessments of quality, because their perceptions are impacted by their expectations and prior experience.

Awareness of entitlements and rights

Mafuta et al. (2015) showed the importance of considering contextual factors and their effect on health behaviours. For example, six out of 20 women from two health zones in the DRC cited it being customary for people not to complain as a cultural factor that prevented them from raising their concerns about available maternal services.

Secondary analysis of data from three studies carried out between 2013 and 2015 in the DRC to improve maternal health services through social accountability mechanisms was conducted by Mafuta et al. (2018). Most of the women could describe the health service they received, however, they were not able to describe what they *should* receive as care. As they had insufficient knowledge of the health services before their first visit, they were not able to explain the mandate of the health providers. The information they received concerned the types of health care they could receive but not the real content of those services, nor their rights and entitlements.

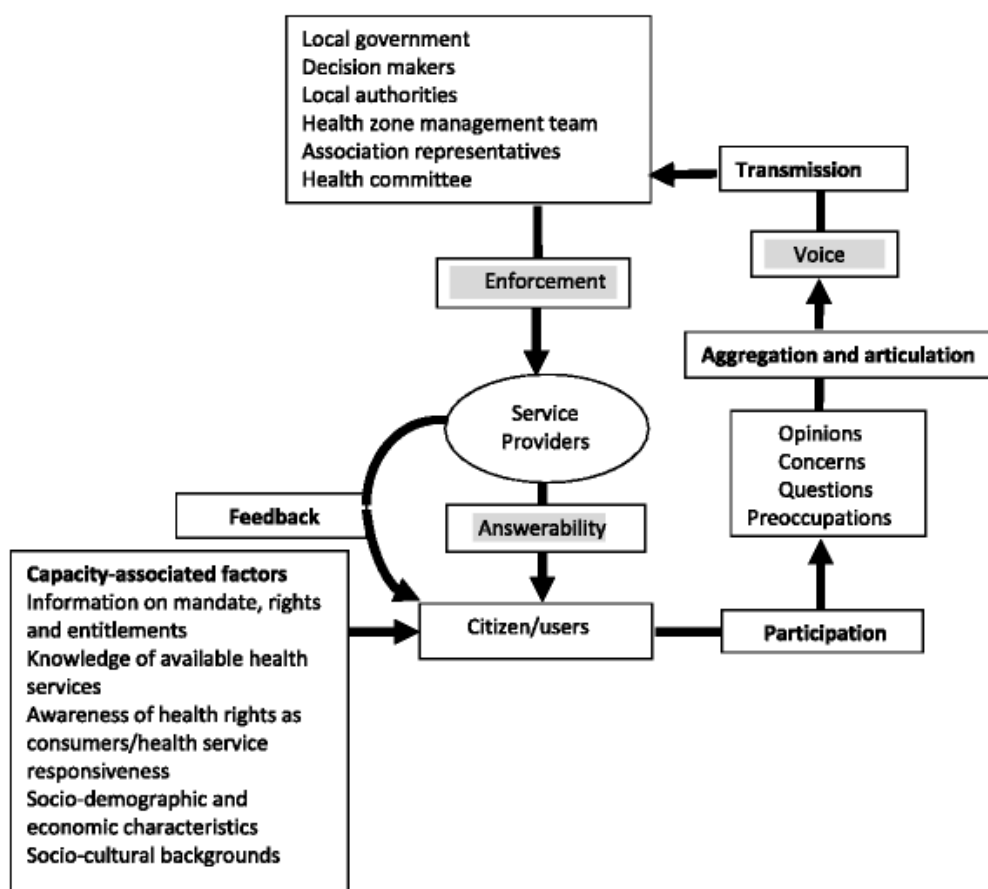
Results showed that they were unaware of their entitlements and rights (Mafuta et al., 2018). They believed that they were laypersons and therefore unable to judge health providers; but when provided with some tools such as a checklist, they reported some abusive and disrespectful treatments. However, community members asserted that the reported actions were not reprehensible acts but actions to encourage a woman and to make her understand the risk of delivery.

Service provider accountability

At the same time, empowerment can also be a prerequisite for bringing about accountability (Waldman et al., 2018). Decentralisation for health is being strengthened in a number of countries. However, research from Kenya and South Africa also reveals that there is limited understanding of the accountability responsibilities and practices of front-line providers and managers within decentralised systems (Nxumalo et al., 2018). Relationships matter: in India, for example, Programme Officers indicated how informal relationships were necessary to generate 'respective and responsive team effort.' Some meetings were revised to encourage provision of feedback, comments and complaints from staff, and collective exchange across staff so that there was shared understanding of particular practices (Nxumalo et al., 2018).

To be effective, the voice of citizens needs to be articulated into actionable demands, and transmitted to the relevant actors and decision makers, who have enforcement capabilities in order to generate answerability from the service providers and local authorities (Figure 1).

Figure 1: Components and steps involved in effective social accountability initiatives



Source: Mafuta et al. (2018: 3, adapted from Baez-Camargo and Jacobs, 2013)²

3. Processes for improving community empowerment

Addressing accountability and improving quality of services through different methods to gain empowerment of communities are explained below. Evidence is from both DRC and other countries:

Animation

At its simplest level, animatorship is the art of animating others to achieve their objectives. Cultural Animation is a bottom-up arts-based methodology of knowledge co-production and community engagement, which employs a variety of creative and participatory exercises to help build trusting relationships between diverse participants (expert and non-experts) and democratise the process of research (Kelemen et al., 2018; McElwee et al., 2018: 174). Cultural Animation encourages participants to imagine and create ideal pictures of health by

² Camargo CB, Jacobs E. (2013). Social Accountability and Its conceptual challenges: an analytical framework. Working Paper Series no 16. Max Planck Society for the advancement of Sciences; Freiburg.

experimenting with new ways of working together. It provides a route to co-produce research agendas, empowers the public to engage actively with health professionals and make a positive contribution to their community.

Somerville (2016)³ argues that much of the literature on community development exaggerates the capacity for poorer communities to advance without significant outside assistance, and points out that successful initiatives tend to have very specific and practical objectives related to community enterprise, community learning, as well as community health and social care (McElwee et al., 2018: 180).

Country evidence: use of media and community volunteers

McElwee et al. (2018: 186) presented case studies illustrating animation in practice across and within a community. However, to protect the anonymity of the respondents, they compiled the cases so as not to identify individuals or villages (McElwee et al., 2018: 195). The only unpaid animator was a community radio volunteer who offered animation across the community; this animator also was the only one stating that sharing (e.g. informal communication, such as face-to-face and social media interactions, using Apps and blogs) was a key part of being an animator; she enjoyed animating other volunteers to provide community services as “an essential part of her vision for change” in improving health of the community (McElwee et al., 2018: 189). As her community profile was high, the community were happy to share ideas with her. Bricolage and brokerage were used on a daily basis, together with the “power of the informal” to achieve clear evidence of impact (McElwee et al., 2018: 182). However, this animator was an atypical volunteer.

Citizen and community engagement

Community engagement has long been proposed as a mechanism by which the quality of health services could be improved. George et al. (2015) conducted a systematic review assessing the state of research, the nature of interventions involved and the features of engagement with communities. The majority of the articles (57/64, 89%) described community participation processes as being collaborative, with fewer describing either community mobilisation or community empowerment (34/64 each, 53%). Research showed that communities became skilled in identifying and prioritising problems; devising action plans; and implementing, monitoring and evaluating the plans. This was a skill common to women’s group interventions where women learned problem solving techniques through participatory learning and action cycles (George et al., 2015: 14). It is through empowerment that communities gain mastery over their lives and change their social and political environment to improve their health and quality of life.⁴ Further evidence from Afghanistan, India, and Uganda, where working with a diverse range of actors - including community leaders and respected peers - resulted in a successfully engaging the community, is displayed in the Future Health Systems Brief (George and Scott, 2016).

Engaging citizens - from policymakers and providers to patients and members of marginalised or disadvantaged groups - is vital to achieving people-centred health research. However, without

³ Somerville, P. (2016). *Understanding Community: Politics, Policy and Practice*. 2nd ed. Bristol: Policy Press.

⁴ Wallerstein N. Powerlessness, empowerment, and health: implications for health promotion programs. *Am J Health Promot.* 1992; 6(3):197–205.

attention to power and difference, engagement can lead to presence without voice and voice without influence, particularly for disadvantaged and marginalised groups who often have the worst health (Pratt, 2018). Existing evidence confirms that being *female*, being *poor*, having *little formal education*, having a *disability*, and/or belonging to certain *ethnic groups* means citizens are listened to less or not at all in health priority-setting (Pratt, 2018).

Power relations are critical to both gender inequities and accountability mechanisms and, while gender is a pervasive driver of inequity in health systems, accountability mechanisms can be used to address and transform health systems to be more gender-equitable (Waldman et al., 2018). Citizen engagement goals include: sharing power with citizens, shaping relevant research questions, and creating positive change/action for health (including for disadvantaged groups). In health systems research, citizen engagement helps ensure that projects' research questions and intervention design reflect the specific circumstances or problems facing the health system of the host community or country. Their engagement has been identified as an ethical imperative because it is central to respect for persons and will likely improve health outcomes, facilitate the stewardship of resources, enhance prospects for justice, and build public trust. Funders, particularly those of applied health research, increasingly expect researchers to engage with citizens *throughout* the research process in countries worldwide. This entails involving citizens not only in shaping research projects' design, conduct, and dissemination but also in setting their research topics and formulating their research questions (Pratt, 2018). However, there remains limited guidance on what inclusive and meaningful engagement in health research entails.

The implication of these concepts for citizen engagement in health research priority-setting is, first, to recognise that such engagement is typically an invited space in practice, where foreign and/or local researchers invite citizens of the host country to participate in research projects. Two types of *power dynamics* are then often recreated within such spaces: those of 'expert' researchers over 'lay' citizens, and those of foreign researchers from high-income countries over researchers from low and middle-income countries (where research is conducted in LMICs).

Where engagement in health research priority-setting is constructed solely for instrumental purposes, this limits its capacity to mitigate disparities in *power over*^{5,6} knowledge production. It will fail to empower citizens in ways that support their right to participate in research and is, therefore, not ideal (Pratt, 2018).

Where engagement in research priority-setting is constructed as transformative, questions to answer are: who is to be empowered and how? At the micro level, it could entail building disadvantaged groups' capacity to participate more effectively in health research priority-setting. This includes strengthening their *power to* understand the agendas and relationships of different stakeholders, to identify research questions, to understand the language of experts, and to debate with them. Empowerment at the micro-level may then serve to facilitate macro-level transformations, gradually shifting *power over* knowledge production away from solely experts

⁵ *Power over* refers to the direct control of one actor over another. The classic definition expressed by Robert Dahl is: 'A has power over B to the extent that he can get B to do something that B would not otherwise do. A and B can be individuals, groups, or organisations. Power over is also exercised where A has control over a particular process or enterprise (e.g. knowledge production, priority-setting) [Dahl RA. (1957). 'The Concept of Power'. *Behavioral Science*, 2(3): 201-215, p. 202-203].

and/or foreigners.⁶ In health research priority-setting at the project level, several stages of entry can be identified: 1) planning the process, 2) research topic solicitation and prioritisation, 3) formulating the research question, and 4) designing the intervention (Pratt, 2018).

Citizen and community scorecards

Community scorecards and Citizen Report Cards, which both provide a structured mechanism for communication between community members and health personnel, are a common type of intervention aimed at promoting community empowerment (Wisniewski and Lusamba-Dikassa, 2018: 8, unpublished). Community scorecards have been conceived as a way to increase accountability and responsiveness of service providers, but there is limited evidence of their effects, particularly in fragile and conflict-affected contexts (Ho et al., 2015).

DRC case study: *Tuungane*

Since 2007 the International Rescue Committee (IRC) and its partner CARE International, have implemented a large-scale community-driven reconstruction project in eastern DRC, named *Tuungane* (“Let’s Unite” in Kiswahili). Ho et al. (2015) describes the implementation of community scorecards within this community-driven reconstruction project in two provinces of eastern DRC.

The most salient changes were related to increased transparency and community participation in health facility management, and improved quality of care. Quality of care included increased access to services, improved patient-provider relationships, improved performance of service providers, and improved maintenance of physical infrastructure. Changes occurred through many different mechanisms, including provider actions in response to information, pressure from community representatives, or supervisors; and joint action and improved collaboration by health facility committees and providers (Ho et al., 2015). Community members and health workers were able to joint-problem solve on a lot of issues (expert comment).

Positive experiences of community scorecards can provide a structured space for interface between community members and the health system, allowing users to voice their opinions and preferences and bridge information gaps for both users and frontline health care providers. When solutions to problems identified through the scorecard are locally accessible, users and health care providers are able to work together to implement mutually acceptable solutions that improve quality of health services, and make them more responsive to users’ needs (Ho et al., 2015). Although it is often assumed that confrontation is a primary mechanism for citizens to change state-provided services, this scorecard study demonstrates that health care providers may also be motivated to change through other means (Ho et al., 2015).

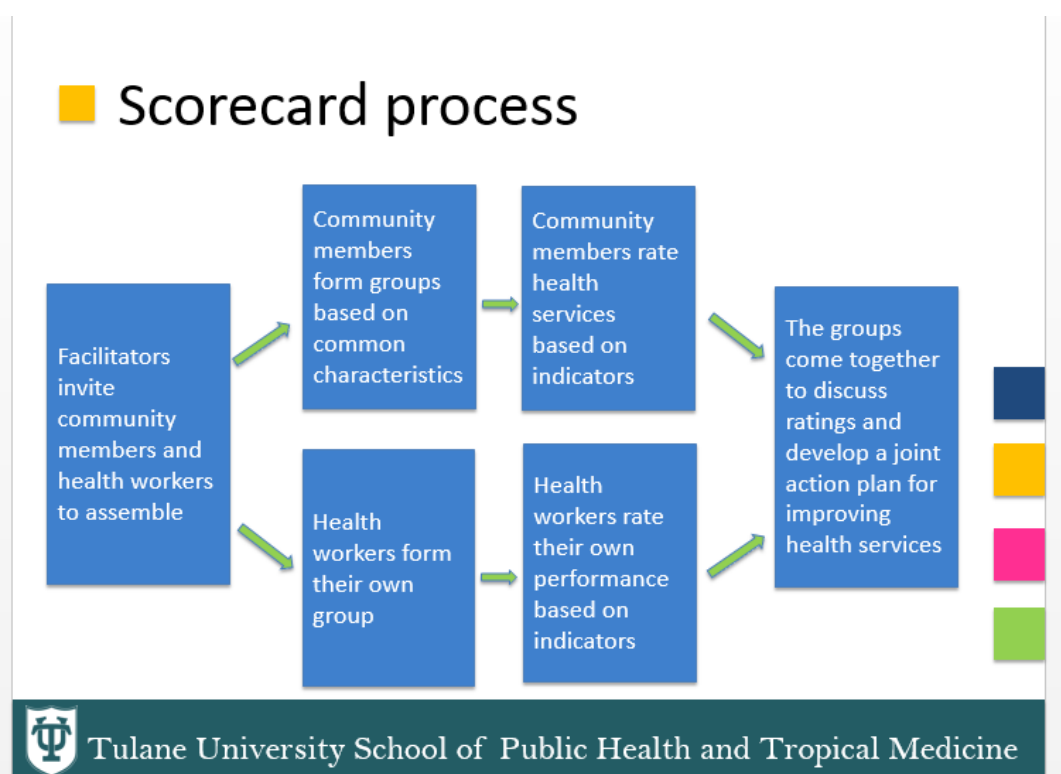
DRC Case study: ASSP

IMAWorld Health (known as IMA), through its *Accès aux Soins de Santé Primaires* (Access to Primary Health Care or ASSP) project has introduced a component for community participatory evaluation of the quality and scope of health services. Specifically, this is a simplified community scorecard, as part of its approach to improve quality and utilisation of health services (Wisniewski and Lusamba-Dikassa, 2018: 4, unpublished). The goals of the community scorecard approach

⁶ Nelson, N., & Wright, S. (1995). *Power and Participatory Development: Theory and Practice*. London: Intermediate Technology Publications.

in the ASSP were to improve service delivery and quality, and to increase utilisation of health services (Wisniewski et al. HSR2018 presentation, 2018). The objectives were to assess the impact of the scorecard on empowerment, service readiness, perceptions of quality, utilisation, and health worker satisfaction. Figure 2 explains the process. Data was collected using household, health worker, and health centre surveys (pre and post); stakeholder interviews, and focus groups (6 months and 12 months post). The project had a positive impact in antenatal care fees, and availability of personal protective equipment. The key finding was that scorecard areas improved more often than non-scorecard areas. Qualitative analysis found that participants saw improvements in health services, and that those impacts were concentrated at the levels at which the community or health workers had direct control (e.g. painting, cleaning, hours of operation, and health worker attitudes). This phenomenon was observed in the *Tuungane* evaluation as well (Wisniewski and Lusamba-Dikassa, 2018: 55, unpublished).

Figure 2: Scorecard process in the DRC



Source: from Wisniewski et al. (2018 HSR2018 presentation)

Key empowerment findings include an improvement in local level indicators. However, communities struggled to get any acknowledgment of the requests that they sent to higher levels of the health system (expert comment). There was simply no incentive for those in power to be responsive and we found that many health zone officers were uninformed about the intervention (due to frequent turnover). This unresponsiveness was cited as a main barrier to the sustainability of the approach.

When asked what positive impacts they had seen from the community scorecard initiative, community members described a newfound sense of the community's ownership of their health services. For example, while many had previously regarded the health centre as the jurisdiction of the head nurse, participating in the scorecard activity convinced them that the community also held responsibility (Wisniewski and Lusamba-Dikassa, 2018: 34, unpublished):

"The exercise has revealed to us that the health center is under the responsibility of the community. We do not need to focus only on bad things done by nurses. We need to endeavor to know how the activities of the health center are going. That is why, after the scorecard meeting, we are following up. When a sick person goes to the health center, we ask him to tell us how he was treated and if he has received medicine." Men's focus group (Wisniewski et al. HSR2018 presentation, 2018).

In addition to the positive impacts, however, the intervention has the potential for unintended impacts. Exclusion from, or even inclusion of, community members in the scorecard process may lead to the disempowerment of women and other vulnerable groups, such as tribal or ethnic minorities and youth (Gaventa and Barrett, 2010; Wisniewski and Lusamba-Dikassa, 2018: 12, unpublished).

Participatory management and monitoring

Participatory management is the practice of empowering members of a group, such as employees of a company or citizens of a community, to participate in organisational decision making. A literature review over a 20-year date range (1994-2014) was conducted by Wisniewski and Yongho (2014, unpublished), comprising of qualitative and quantitative studies, case reports, programme evaluations and theoretical papers. Moving beyond simple participation, there has also been a surge of support for community evaluations, where community members play a direct role in evaluating the performance of health care workers and the health system (Wisniewski and Yongho, 2014 unpublished). The following lists how this process helped two countries:

Country evidence: Niger and Ethiopia, IMCI

Since the mid-1990s, UNICEF and the WHO have promoted Integrated Management of Childhood Illness (IMCI) as the comprehensive service delivery model at primary care level to allow sick children the right to quality medical care. In 2016, 83% of countries reported implementing the community component, but this proportion fell to 69.2% in countries where IMCI is not implemented at scale (less than 50% of districts) (WHO, 2017).

Media can be used to strengthen community health systems by ensuring bottom-up accountability, health system responsiveness, and participatory decision-making processes. Successful mechanisms, in Niger for example, have included community dialogues and media messages (cinema, community radio, and theatre) to disseminate information on promotion and prevention (Sharkey et al., 2014). Ethiopia has developed innovative mechanisms to support the community, whereby the Ministry of Health prioritised the implementation of community-based preventive, promotive, and curative care through the health extension programme. As a result, the community component of IMCI received advanced support from both government and health development partners. Subsequently, the innovative Health Development Army was introduced, training community-level volunteers to focus on local behaviour change. The HDA is a network created between five households and one model family to influence each another in practising

healthy lifestyles. To date, the government has been able to mobilise over three million women in the HDA (Balcha et al., 2015). Since the 1997 adoption of IMCI, Ethiopia has reduced infant mortality from 162 in 1000 live births in 1997 to 59 in 1000 in 2015.

Strengthening social accountability

Social accountability is a participatory process in which citizens are engaged to hold politicians, policy makers and public officials accountable for the services that they provide (Danhoundo et al., 2018: 1). On the one hand, it comprises a set of mechanisms aiming to enable users to raise their concerns about the health services provided to them (voice), and to hold health providers accountable for actions and decisions related to the health service provision. On the other hand, they aim to facilitate health providers to take into account users' needs and expectations in providing care (Mafuta et al., 2017).

Mechanisms introduced to strengthen community accountability can be distinguished by expected impact (financial, performance, or political/democratic), and by depth of community involvement expected or achieved (Molyneux et al., 2012). In the DRC, through interviews with 35 community members and health officials, Mafuta and colleagues (2016) identified the following factors as facilitators of social accountability initiatives: community associations and groups; experiences in social mobilisation and networking; cultural diversity and marginalised population; women's status and participation in community groups' activities; existing media and access to information; supportive regulatory environment; resources, and negotiation ability.⁷ Mafuta et al. (2017) made similar identifications, in addition to emphasising the support of health zone management teams in community participation activities, and improving the attitude of health providers towards voice at the health facility level. The authors describe the development of a social accountability intervention that aimed to improve health services responsiveness in two health zones in the DRC. Beneficiaries including men, women, community health workers, representatives of the health sector and local authorities were purposively selected and involved in an advisory process using the Dialogue Model. The use of the Dialogue Model, a participatory process, allowed beneficiaries to be involved with other community stakeholders having different perspectives and types of knowledge in an advisory process and to articulate their suggestions on a combination of social accountability intervention components, specific for the different health zones contexts. The effect of strengthening accountability in Benin is described below:

Country evidence: PISAF - Center for Research in Human Reproduction and Demography (CERRHUD), Benin

The Integrated Health Services Project (PISAF), a five-year USAID-funded project (2006- 2012), aimed to reduce the morbidity and mortality of mothers, infants, children and adolescents. It addressed the challenges related to the supply and use of health services in Benin. It built on the capacity of local government, health sector leaders, and community members to ensure availability, adoption, quality, sustainability and funding of health services. Through the President's Malaria Initiative (PIF), the co-funder, PISAF improved the capacity of health services staff and managers and strengthened facility-based services. It also strengthened national-level

⁷ They also identified certain contextual factors that limit social accountability initiatives: lack of networks, insufficient capacity for community mobilisation, poor socioeconomic conditions (e.g. poor wages, lack of safe water and electricity), lack of radio and media coverage in rural levels, and poor negotiation ability.

data collection and reporting systems for malaria. It improved the quality of family health services by engaging health workers in improvement collaboratives, and in the use of data for decision making. It also increased financial access to health services by supporting membership in 57 community-based insurance organisations or "mutuelles." Community mobilisation campaigns were conducted to increase demand for family health services. Capacity of community health workers was built-up to treat common childhood illnesses (e.g. malaria, diarrhoea, and pneumonia) in the home.⁸

4. Evidence on communities prioritising and delivering areas of change

The DRC Emergency Social Action Project Additional Financing (Project ID: P126683, 2011) aimed to "improve access to social services by the poor and enhance management of development resources at the community level." However, according to the World Bank this project is now closed. The Global Fund⁹ also notes that most of the funding for DRC is "Administratively Closed" or "In Closure." However, there is some information on community grants and participatory budgeting:

Community grants

DRC case study – IRC RAcE:

In 2012, the Government of Canada awarded a grant to the World Health Organisation (WHO) Global Malaria Programme to support the scale-up of integrated Community Case Management (iCCM) of pneumonia, diarrhoea and malaria among children under 5 years in sub-Saharan Africa. Through the Rapid Access Expansion Programme (RAcE), WHO awarded implementation funding to non-governmental organisations selected through a competitive process.¹⁰ RAcE partners have given logistical, technical and financial support to implementing countries for iCCM scale-up.

The NGO International Rescue Committee (IRC) has been implementing the RAcE programme in the Tanganyika Province of the DRC since September 2013. IRC developed simplified pictorial tools and an improved training package for *relais communautaires* (community health workers) who often have low-literacy (Wittcoff, 2017). As a result, children were three times more likely to receive correct treatment from *relais* than in the intervention group.

Kenya case study - HSSF:

In Kenya, whilst facility committees have in the past been responsible for overseeing the operations and management of health facilities and user fees, their roles were extended in 2010

⁸ <https://www.urc-chs.com/projects/benin-integrated-family-health-project-projet-int%C3%A9gr%C3%A9-de-sant%C3%A9-familiale-pisaf>

⁹ <https://www.theglobalfund.org/en/portfolio/country/list/?loc=COD&k=8821256b-ea63-4407-adbf-3ddf43878055>

¹⁰ http://www.who.int/malaria/areas/rapid_access_expansion_2015/overview/en/

to manage facility budgets allocated from the Health Sector Services Fund (HSSF) (KEMRI Wellcome Trust, 2014b).

The HSSF is an innovative financing initiative established by the Government of Kenya (GOK) under the Ministry of Public Health and Sanitation (MOPHS) that disperses funds directly from the central government into facility bank accounts (health centres and dispensaries - level 2 and 3 health facilities, respectively). It aims to ensure funds reach facilities, and aims to make up for shortfalls in facility-level funding following the reduction in user fees in 2004. HSSF provides facility committees with larger budgets to manage, which has required new roles and responsibilities. Health Facility Management Committees, which include local residents and the facility in-charge, are responsible for planning, budgeting and implementation of HSSF activities (Goodman et al., 2018). Researchers from KEMRI-Wellcome Trust Research Programme and the London School of Hygiene & Tropical Medicine (LSHTM) were evaluating the HSSF until 2016. Key findings available from a mixed-methodology interim evaluation of HSSF and its implementation until May 2013 are listed below (KEMRI Wellcome Trust, 2014a):

- Peripheral facility finance mechanisms can have a strong and broad positive impact on peripheral facilities.
- HSSF has led to improvements in the reported quality of care, staff motivation and patient satisfaction, even when funds represented less than 1% of the total health sector budget, and without any link between funding and performance.
- Community members are more actively involved in the running of facilities as part of health facility management committees, which has strengthened accountability.
- Challenges to effective implementation remain, in particular delays in receiving funds and arduous financial reporting requirements, both of which can affect the ability of facilities to deliver services effectively.
- In any low-income setting, there are limits to the possible achievements of one financing intervention in the context of wider challenges, including unreliable drug supplies, poor access to emergency transportation, and shortages of qualified staff.

DRC case study: ASSP and *Tosalisana* in Yakoma

At the main general hospital, Hôpital Général de Référence de Yakoma, on the border with the Central African Republic, the *Access to Primary Health Care project*, known locally as ASSP, has made a difference that is reflective of the change that has occurred throughout the health zones where ASSP is working in the DRC. A team of IMA¹¹ analysts recently looked at the financial performance of the Yakoma Hospital in the Yakoma Health Zone, Nord-Ubangi province, which has one of the lowest rate of health indicators in all of the ASSP project's provinces (IMA, 2018). At the beginning of the ASSP project in 2012, when a woman gave birth by caesarean section, she would expect to receive a hospital bill of 100,000 Congolese Francs (approximately USD100). Very few people can afford to pay such a high price. To supplement the support received from the ASSP project, the community of Yakoma created a health co-operative that they named *Tosalisana*, which means "let's help ourselves" in Lingala, the local language. These two entities have given the community better access to health care. The price of medical services

¹¹ IMA founders are protestant churches and church-based organisations.

dropped and became more affordable. For instance, the cost of a C-section is now approximately USD10 and a regular birth is about USD3.30.

For a fee of 3,000 Congolese Francs (about USD2) per person for an annual membership in the co-operative, patients saw their medical bills reduced by 40% of the original bill. The co-operative covers the balance of 60%. However, *Tosalisana* got off to a slow start due to Yakoma's painful history with the previous organisation that handled all of the hospital's finances. That organisation went bankrupt and suddenly disappeared in 2012. Many people in Yakoma lost the money they had contributed to that organisation, which had partially functioned as a health co-operative. So, three years later when the new co-operative started its outreach activities in the health zone, the community was wary. However, once the population began to see the benefits of the new co-operative, they again became interested in contributing. Patients began lining up for the consultations, medication and surgeries that they had not been able to afford in the past.

Located in an impoverished community of 102,244 inhabitants, the co-operative continues to gain membership. As of 2017, it had 5,151 members - already 50% of the necessary membership to operate at maximum efficiency.

DRC case study - USAID and IMA:

In response to the humanitarian crisis in the Kasai and Central Kasai provinces, the '*Health Care Services For Vulnerable Populations And Internally Displaced Persons*' project has been providing free primary health care services to internally displaced persons and destabilised populations made vulnerable by recent militia and ethnic violence in the conflict-affected provinces, where IMA has been managing a health-systems strengthening development project (ASSP) for the past four years.¹²

The aim of this project is to make health care free at a time when health needs are increased due to the violence, stress and physical duress that internal refugees are subjected to in repeatedly fleeing their villages. This project is providing health care to a population of 1,844,000 people. Of that total, the number of targeted internal refugees is 1,309,850. USAID Office of U.S. Foreign Disaster Assistance provided USD1.5 million from September 2015 to June 2017.

Rather than bring in humanitarian organisations to provide free care to the population, IMA proposes a unique approach: providing short-term emergency financial support to a previously increasingly functional national health care delivery system in order to meet the acute needs of the destabilised population affected by the violence in the region. In doing so, this humanitarian response and emergency financial support would contribute to further strengthening the ongoing development work and increasing the system's resilience rather than undermining it by establishing a parallel health service delivery system during this time of dire need.¹²

DRC case study: Caritas Congo in Kinshasa

Caritas Congo, a local NGO established in the capital Kinshasa since 1960, covers community level activities in support of the national tuberculosis programme and procurement of drugs through the Global Drug Facility mechanism. It manages one grant of USD38.96 million (The

¹² <https://imaworldhealth.org/democratic-republic-of-congo/>

Global Fund, 2016: 5). This work was carried out through projects, implemented by some of its Caritas-Diocesan Offices, whose interventions are not included in the annual report.¹³

Participatory Budgeting

Participatory Budgeting is an innovative process which enables residents to have direct decision-making powers over the allocation of resources in their communities in a way that is fair and transparent. It is a system in which citizens have control over how public funds are allocated. Although a formal evaluation is not yet available, this approach has shown promise in the DRC, where a participatory budgeting intervention in South Kivu Province contributed in an increase in public investment from 0% to 11.6% over the course of one year. However, participatory budgeting comes with significant operational and political challenges which may limit its success (Wisniewski and Yongho, 2014: 10, unpublished).

DRC case study: ICT4Gov in eastern DRC

In the DRC, Information and Communication Technologies (ICTs) are helping increase citizen participation, positively transforming the relation between citizens and their government, ultimately resulting in more effective public service delivery.

Mobile phones are performing a key role in enhancing transparency and accountability. Mobile penetration in the DRC is increasing rapidly, from 16% to an estimated 47% in 2013. In addition, 55% of the country's population resides in areas currently covered by mobile networks, including most rural areas from the eastern province of South Kivu (Estefan and Weber, 2012).

The World Bank Institute's ICT4Gov programme is introducing mobile technology to enhance participatory budgeting processes. Citizens are now empowered to demand and work towards improved governance. To enhance these efforts, ICT4Gov is using mobile phones for four purposes: 1- to communicate information to participants; 2- collect votes from those who are not present about their preferences and priorities for public projects; 3- report back on projects that were undertaken, and 4- engage in monitoring and evaluation of ongoing projects. Through mobile technology, citizens can now express and vote on the priorities that are most pressing for their communities. When they have reached an agreement the local government devotes a percentage of the local investment budget to the project selected by the citizens.

Since the beginning of the programme, as the Provincial government sees an increasing capacity of the local government to better allocate resources; communities involved have already seen an increase in transfer of funds from the Provincial to the local level. The preliminary results of an external evaluation suggest a reduction of tax evasion at the local level, with citizens more willing to pay taxes as they link government spending to improvement in the delivery of services. For the first time, communities such as Ibanda have gone from not having any investment budget to having 40% of their budget devoted to investments. In 2011, the Ministry of the Budget started the process of institutionalisation of Participatory Budgeting in the Province.

¹³ <https://reliefweb.int/report/democratic-republic-congo/drc-nearly-8-million-people-benefited-actions-carried-out-caritas>

DRC case study: *Tuungane* Development Grants in eastern DRC

A component of the *Tuungane* intervention in eastern DRC was the distribution of development grants to community committees. The committees were free to use the grants as they chose. Committees invested the grants in projects related to agriculture, education, health, water and sanitation, and transport. However, the project's effect on community cohesion, levels of trust, and transparency were disappointing. Further, there was some evidence that economic status decreased in intervention areas (Wisniewski and Yongho, 2014: 10, unpublished).

Programmes promoting understanding of rights

Country evidence: South Africa - Patients' rights charters

Patients' charters are guidelines that target the relationship between health professionals and users of health services, providing information on standards of care that patients can expect to receive and demand as a basic human right.¹⁴

London et al.¹⁴ observed that patients' rights posters and suggestion boxes were common in facilities, and that facility staff and managers were often positive about the charter and its ability to motivate staff. There were concerns about sustainability of positive effects however, and many negative sentiments and dynamics. For example, many providers complained that the charter gave patients' rights without emphasising their responsibilities; this led to patients 'expecting miracles,' and to health workers being 'taken for granted;' also, that the charter failed to recognise health workers' own stresses and challenges. Ultimately, the charter was seen as a threat or weapon, 'a sword over the head of health workers;' increasing stresses and strains, rather than improving relations (Molyneux et al., 2012).

Programmes changing expectations of services

DRC case study: Oxfam pilot in Wendji

Oxfam established a DRC pilot project in the ongoing global protection programme *Within and Without the State* (WWS). A governance approach is integrated throughout the programme, and the evidence indicates that this has been critical to the success of the programme in achieving its wider protection aims (Lindley-Jones, 2017: 5). This approach has two key pillars: 1- supporting and empowering citizens, and 2- facilitating engagement with duty bearers. Programme evaluations have revealed that the success of the programme rests on the effective empowerment of members of Community Protection Structures and community members more widely; developing their knowledge, confidence and skills to take action. Dialogues, such as door-to-door conversations, 'quick chats' and community meetings, are promoted.

In Wendji, the Development Structures had identified that access to health care and high maternal mortality was a major problem. This was raised during a *Réunion Mixte* (joint meeting), and separate meetings were then held with the *Medecin Directeur* and local nurses following this

¹⁴ London L, Holtman Z, Gilson L, et al. (2006). Operationalising Health as a Human Right: Evaluation of the Patients' Rights Charter and Monitoring Mechanisms for Human Rights in the Health Sector. Cape Town, School of Public Health, University of Cape Town.

initial meeting. The *Medecin Directeur* then published the legal price of different fees at the health centre, to reduce confusion over the appropriate amount to pay, and instigated a dual pricing system in order to encourage mothers to attend pre-natal consultations. Under this dual pricing system, if an expectant mother has attended pre-natal consultations, then certain medical fees, such as the fee to give birth at the health centre, are reduced, in this case from USD16 to USD2 (Lindley-Jones, 2017: 12). As female ‘change agents’ took the lead in presenting the development plans in the first *Réunion Mixte*, participants reported that women now regularly share their views in the Development Structure meetings, which are listened to and respected by the male members (Lindley-Jones, 2017: 10).

DRC case study: AcQual in Kinshasa and Kongo Central

The Access and Quality of Family Planning Services II Project (AcQual) works in the DRC provinces of Kinshasa and Kongo Central to improve the quality of sexual and reproductive health services, expand the community-based distribution of contraceptive methods, and conduct research on innovative strategies for contraception distribution. Promising initiatives are being implemented to improve the supply and quality of services and generate demand for family planning, including social marketing of subsidised contraceptives at both traditional and non-traditional channels, and strengthening of services in military health facilities (Kwete et al., 2018).

The Johns Hopkins Centre for Communication Programmes is responsible for creating demand for family planning methods and services, with a particular focus on youth.¹⁵ The greatest “discovery” of the study was the potential of using students to expand access to contraception. They are dynamic, well educated, eager to gain experience with service delivery at the community level, and young (thus approachable to young people seeking contraceptives). In addition, they represent tomorrow's leaders of the DRC health care system (Kwete et al., 2018).

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Key websites

- www.copasah.net: COPASAH (**Community of Practitioners on Accountability and Social Action in Health**) is a southern-led global community of practitioners engaged in community-centred and citizen-led processes of accountability in health, and in facilitating shared practice and bottom-up knowledge building. COPASAH is organising a Global Symposium on Citizenship, Governance and Accountability in Health, on the theme – Role of the Community in Strengthening Performance and Accountability of Health Systems for Achieving Universal Health Care/ SDGs (15–18 October 2019, New Delhi, India). The Symposium aims to facilitate a dialogue between practitioners, policymakers and researchers.

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